TAP POST-COUNSELING CLIENT SURVEY FORM

NOTE: Please complete and return this form in the provided envelope within 10 days after you complete or discontinue your treatment program. If you were not supplied an envelope, please send the completed form directly to: Treatment Assistance Program (TAP), c/o the Office of Problem Gambling, 202 E. Earll Drive, Suite 200, Phoenix, AZ 85012, Personal and Confidential

- -

Client #_____

This survey form was compiled by TAP of the Office of Problem Gambling. Ask your counseling office for a TAP brochure if you have not received one. The purpose of this survey is to gather opinions of clients who have used the TAP network of treatment providers (counselors). We are seeking your post-counseling feedback in an effort to assure that the gambling treatment program is operating efficiently and effectively and continuously improving. Completion of this form is strictly voluntary, and the results will be kept totally confidential. Your responses will be compiled with the responses of other clients in a statistical format that will have no ties to your identity. Your counselor will neither see nor have access to your completed survey at any time.

Instructions: Circle the response that best describes how you feel about each statement, or otherwise complete as requested. Circle "No Opinion/NA" when you have no opinion or the statement does not apply to you. Please feel free to make additional comments to explain or justify your response to any questions.

1. **When I called for an appointment with my counselor, I was scheduled within a reasonable time frame.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
2. **The distance and travel time required to meet with my counselor was reasonable.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
3. **The counseling office staff was courteous, friendly, professional and helpful.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
4. **My counselor assessed my treatment needs, including referrals to other resources if necessary, within the first two weeks of my treatment.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
5. **My counseling sessions normally began on time as scheduled.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
6. **My counseling sessions were rarely if ever cancelled or postponed by my counseling office.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
7. **I felt comfortable sharing my problems with my counselor.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
8. **I had full confidence in my counselor.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA
9. **There were no language, communication or cultural problems between my counselor or office staff and me.**
   Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

10. My counselor explained the recommended treatment plan satisfactorily.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

11. My counselor and I established goals within my treatment plan.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

12. On scale of 1 to 5, with "5" meaning "extremely helpful", and "1" meaning "not at all helpful," please assign a number indicating how helpful you rank each of the following components of your treatment plan. If any did not apply to you, please place a "0" in front of that component.

___Gaining coping skills
___Gaining a sense of empowerment
___Learning to deal more effectively with "codependency"
___Dealing with past as well as present life issues
___Learning relapse prevention techniques
___Having a financial assessment/participating in financial planning
___Making "after-care" plans
___Other (specify):_____

Comments: _____

13. I met all or nearly all of the goals established within my treatment plan.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

14. Individual counseling was helpful.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

15. Crisis phone counseling was helpful.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

16. Group counseling was helpful.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

17. Family counseling was helpful.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

18. During my treatment, I abstained from gambling.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

19. During my treatment program, I was encouraged to attend Gambler's Anonymous or Gam-Anon meetings on a regular basis.

___Yes ___No Comments:
_____

20. During my treatment program I attended Gambler's Anonymous or Gam-Anon meetings on a regular basis.

___Yes ___No Comments:
_____

21. I currently attend Gambler's Anonymous or Gam-Anon meetings on a regular basis.

___Yes ___No Comments:
_____

22. I have found Gambler's Anonymous and/or Gam-Anon meetings to be helpful.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

23. I have minimized most of my problems related to gambling.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

24. I completed the treatment program as recommended by my counselor.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

25. Overall, I was pleased with the results of my treatment program.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

26. I need further treatment for my gambling-related problems.

Strongly Agree Agree Disagree Strongly Disagree No Opinion/NA

27. If further counseling is necessary, I would return to the same counselor I previously used.

___Yes ___No Comments:
_____

28. Upon completion or discontinuation of my treatment program, my counselor and I developed a plan to assure continuation of the progress I had made.

___Yes ___No Comments:
_____

29. If you developed a plan, which of the following were a part of that plan? (place a checkmark in front of each that applies):

___Gambler's Anonymous or Gam-Anon meetings
___Continued Counseling
___After-Care Program (please describe):_____
_____

30. I would recommend my counselor to others with gambling-related problems.

___Yes ___No Comments:
_____

Please feel free to share any other feelings about your treatment, treatment system or problem gambling issues below:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Would you be willing to participate in future surveys?

_____Yes _____No (Note: We will only send you future survey forms if you answered “Yes”).

If you answered “Yes”, please provide the mailing address you wish us to use:
Name (indicate “occupant” if you prefer no name be used) _____

Address_____

City_____State_____Zip Code_____

Phone if you are willing to be contacted by phone __

Thank you for participating in this confidential survey. Your opinions will help assure a better understanding of problem gambling and pave the way to improve the lives of problem gamblers and their families.

TAP Form 12/12/05

TAP Client Satisfaction Survey Consent Form

The Treatment Assistance Program (TAP) of the Office of Problem Gambling is making every effort to continuously improve the treatment program for problem gamblers and family members. In order to assure improvements, we believe that feedback from clients in the program is not only desirable, but essential. We hope you will agree to participate in our client survey, but assure you that your decision will in no way affect the services you receive. Further, should you consent to participate, you may change your mind at any time by merely completing a replacement form to indicate your desired change.

All survey responses will be kept COMPLETELY CONFIDENTIAL and only used in statistical formats without use of your name or any other identifiable characteristics. Your responses will be compiled with the responses of other clients for the purpose of analyzing the program and making improvements in services.

If you agree to participate, your counselor will provide you with the survey and mailing envelope to take home at the conclusion of your treatment program. Please complete and return the form directly to TAP. Your counselor will neither see nor have access to the completed form at any time.

Please check the appropriate boxes below:

1. I agree to participate in the TAP Client Satisfaction Survey upon completion of my treatment program. I understand that my survey will be kept totally confidential and used only for statistical purposes designed to improve the program. _____Yes _____No

2. If I leave the TAP program services before completion of my planned program, I give my counselor permission to mail the Client Satisfaction Survey to the address I have provided at the time of intake or to another address that I specify. _____Yes _____No

I understand that if any time during my treatment I change my mind about participating, I may complete a replacement form. I further understand that services and their quality are not affected regardless of my decision to participate in the survey.

Name of Client_____

Signature of Client_____

Date_____

* Expiration Date of Consent Form_____

***Expiration date is automatically nine (9) months from date of signing unless client chooses another date.**

TAP Form E-1 (10-21-03)